



State of Missouri – Department of Mental Health Reasonable Accommodation Request Form

The Department of Mental Health is committed to complying with the Americans with Disabilities Act (“ADA”). To be eligible for an ADA accommodation, you must be 1) qualified to perform the essential functions of your position and 2) have a disability that limits a major life activity or function. Your Human Resources Office will review each request on an individualized case-by-case basis to determine whether or not an accommodation can be made.

Employee/Applicant Name:	Job Title:
Work Location:	Phone Number:

Data Privacy Statement: This information may be used by your agency human resources representative, your agency legal counsel, or any other individual who is authorized by your agency to receive medical information for purposes of providing reasonable accommodations under the ADA. This information is necessary to determine whether you have a disability as defined by the ADA and to determine whether any reasonable accommodation can be made. The provision of this information is strictly voluntary; however, if you refuse to provide it, your agency may refuse to provide a reasonable accommodation.

A. Questions to clarify accommodation requested.

1. What specific accommodation are you requesting?
2. If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore?
YES NO
 - a. If yes, please explain.

B. Questions to document the reason for the accommodation request (*please attach additional pages if necessary*).

1. What, if any, job function are you having difficulty performing?

2. **What, if any, employment benefits are you having difficulty accessing?**
3. **What limitation, as result of your physical or mental impairment, is interfering with your ability to perform your job or access an employment benefit?**
4. **If you are requesting a specific accommodation, how will that accommodation be effective in allowing you to perform the functions of your job?**

Employee/Applicant Signature:

Date: _____

Fax Completed Form To The Attention of Sara Murphy and Dianne Sackett at (573) 526-4561

This authorization does not cover, and the information to be disclosed should not contain, genetic information. "Genetic Information" includes: Information about an individual's genetic tests; information about genetic tests of an individual's family members; information about the manifestation of a disease or disorder in an individual's family members (family medical history); an individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; and genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.



Medical Inquiry Form
ADA Reasonable Accommodation Request
State of Missouri – Department of Mental Health

Information Pertaining to Medical Documentation: In the context of assessing an accommodation request, medical documentation is required to determine if the employee has a disability covered by the ADA and to assist in identifying an effective accommodation. It is the responsibility of the employee to ensure this form is completed by the medical provider and returned back to the employer in order to complete the accommodation request.

Medical providers are asked to complete each section and fax back the signed and dated original form using the contact information on the attached document which also includes a description of the employee's job duties.

A. Questions to help determine whether the employee has a disability.

1. **Existence of impairment:** For reasonable accommodation under the ADA, the employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such impairment.

Does the employee have a physical or mental impairment?

YES NO

a. If yes, what is the impairment?

2. **Limitations on major life activities:** Answer the following question based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, assistive technology, auxiliary aids or services, prosthetics, etc. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit a major life activity as compared to most people in the general population?

YES NO

a. If yes, what major life activity(s) (including major bodily functions) is/are affected? (Please circle).

Bending	Hearing	Reaching	Speaking
Breathing	Interacting with Others	Reading	Standing
Caring for Self	Learning	Seeing	Thinking

Concentrating	Lifting	Sitting	Walking
Eating	Performing Manual Tasks	Sleeping	Working
Other (Describe):			

Major Bodily Functions:

Bladder	Digestive	Lymphatic	Reproductive
Bowel	Endocrine	Musculoskeletal	Respiratory
Brain	Genitourinary	Neurological	Special Sense Organs
Cardiovascular	Hemic	Normal Cell Growth	Circulatory
Immune	Operation of an Organ		
Other (Describe):			

3. Duration: Describe the nature, severity and anticipated duration of the impairment.

Temporary (explain):

Anticipated duration:

Temporary with residual side effects (explain):

Permanent:

Episodic/In Remission (explain):

B. Questions to help determine whether an accommodation is needed.

- 1. What limitation(s) is interfering with job performance or accessing a benefit of employment?**

- 2. What job functions (description attached) or benefits of employment is the employee having trouble performing or accessing because of the limitation(s)?**

3. How does the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access a benefit of employment?

C. Questions to help determine effective accommodation options.

1. Do you have any suggestions regarding possible accommodations to improve job performance?

YES NO

- a. If so, what are they?

2. How would your suggestions improve the employee's job performance?

D. Other Questions or Comments:

Health Care Provider Name: _____

Health Care Provider Address: _____

Health Care Provider Phone Number: _____

Health Care Provider Signature: _____

Date: _____

Fax Completed Form To The Attention of _____ and _____ at FAX #

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